	Worcester
Berkshire	Berkshire
Springfield	Hampden
	Hampshire
Barnstable	Barnstable
	Dukes
	Nantucket
Rural	Franklin

e. In order to be eligible for this CBC, a hospital must demonstrate that it is facing extraordinary difficulties in the market for direct care staff, as indicated by one or more of the criteria established in St. 1988, Chapter 270. These criteria include, but are not limited to:

(i) existence of significant vacancy rates for a period of time sufficient to jeopardize the welfare of patients according to Department of Public Health standards, JCAHO standards or other qualifying guidelines utilized in Massachusetts to ensure adequate care;

(ii) persistent difficulty in recruitment given bona fide recruitment efforts to obtain staffing levels referenced in 114.1 CMR 40.08(4)(e)7.e.(i); and

(iii) existing dependency upon temporary nursing services in order to maintain staffing levels referenced in 114.1 CMR 40.08(4)(e)7.e.(i).

f. This CBC shall not produce reimbursement exceeding actual rate year expenditures for such direct care staff.

8. An increase in inpatient care costs generated by increased care or services required by a more intensely ill patient population. The hospital shall have the burden of demonstrating a net increase in intensity from the base year to the intermediate or rate year. The higher intensity level in the intermediate or rate year shall be used to adjust RFR.

a. To document that an increase in intensity has taken place between the base year and the intermediate year, a non-acute hospital may use any JCAHO-mandated measures of minimum staffing requirements mutually acceptable to itself and to the Division, or the management minutes system, in either case with results subject to verification by the Division or its agents. Alternatively, psychiatric hospitals may demonstrate that hospital-wide increases in certain intensity factors between the first eligible year and the intermediate year (intensity factors include, but are not limited to changes in age mix, average length of stay, number of involuntary lockup patients, patient disability index, and percentage of patients admitted from an acute hospital) have led to increases in hospital-wide service intensity (e.g., FTEs, nursing hours per patient), which in turn have led to quantifiable increases in cost. Note that increases in inputs alone are not enough to qualify for an intensity CBC; some intensity-related change in patient characteristics must also be identified.

b. If the documentation for the increase in intensity is found to be acceptable, then the hospital shall have the burden of documenting the increase in patient care costs resulting from the higher level of intensity.

9. Costs for increases in physician malpractice insurance premiums paid by the hospital for physicians who are employees of the hospital and who do not bill patients or third party reimbursers separately for their professional services. The amount of the approved CBC will be net of all the increases already determined through the inflated adjusted base year costs. The hospital must document the actual malpractice insurance premium expense, as well as show that the physicians covered are employees of the hospital and do not bill separately for their services. The hospital may include in its request the amount of any retroactive premium payments to be made during the rate year.

(c) No costs other than those meeting the criteria set forth in one or more of the categories enumerated in 114.1 CMR 40.08(4)(b) are allowable CBCs. A cost increase which is affected by or attributable to a hospital's voluntary business decision is not a CBC. An increase in the cost of doing business which affects the industry as a whole is not a CBC.

(5) New Services.

(a) The Division shall recognize as a new service any health services that were not offered by a hospital prior to the intermediate year. In order to be recognized as a new service by the Division, the service to be provided should conform with the cost centers as defined in the HURM Manual. The Division shall not approve any cost allowances for a new service that is not scheduled to start within six months.
(b) For a new service to be implemented after the start of the hospital's rate year, the allowable cost shall be equal to the reasonable operating costs attributed to the new service cost centers. For a new service started in the base year, the allowable cost shall be equal to the reasonable base year cost attributed to the new service inflated by a base to rate year inflation factor plus a base to rate allowance for volume adjustment attributed to the new service.

(6) Capital. The base year capital requirement shall be adjusted to include reasonable projected acquisitions and retirements of fixed equipment and plant, and reasonable projected increases and decreases in amortization, leases and rentals. The limitations to allowed base year capital costs defined in 114.1 CMR 40.07(3) apply to these adjustments as well.

40.09: New Hospitals

(1) New Hospitals.
(a) For hospitals which were not licensed and/or operated as non-acute hospitals in FY 1993, or did not report a full year of actual costs in FY 1993, the base year for operating and capital costs shall be the year used in the hospital's first RFR calculation.
(b) If the base year RFR was not based on a full year of actual costs, the Division shall determine whether to utilize base year RFR information, establish a different base year in accordance with Medicare regulations at 42 CFR 413.40(f)(1)(i), or to evaluate the hospital's projected operating and capital costs for reasonableness. Criteria for such review will include, but are not limited to, peer group analysis of costs incurred by comparable facilities.
(c) For new hospitals where base year RFR information is not used, the Division shall make any necessary adjustments to the provisions of 114.1 CMR 40.07 and/or 114.1 CMR 40.08 to reflect the use of a different data source.
(d) For new hospitals, which were not licensed and/or operated as non-acute hospitals in FY 1996, or did not have a base year previously established, the base year for operating and capital cost shall be the first full year of hospital cost pursuant to 114.1 CMR 40.06. If the Division determines that the data source is inadequate or not representative of the hospital's ongoing costs, the Division may consider alternative data sources to determine Base Year costs. Criteria for such review will include but will not be limited to peer group analysis of costs incurred and the determination of approved rates for comparable facilities.
(e) For FY 1997, the PAF shall be based upon projected cost determined by 114.1 CMR 40.09(1)(d) and projected GPSR. The projected inpatient GPSR shall be reviewed by the Division for reasonableness against the Charge per Medicaid Inpatient Day for comparable facilities.

40.10: Medicaid Disproportionate Share Adjustments

The Medicaid program will assist hospitals which carry a disproportionate financial burden of caring for the uninsured and low income persons of the Commonwealth. In accordance with Title XIX rules and requirements, Medicaid will make an additional payment adjustment to hospitals which qualify for such an adjustment under any one or more of the following classifications. Eligibility requirements for each type of disproportionate share adjustment and the methodology for calculating these adjustments are described in 114.1 CMR 40.12 through 114.1 CMR 40.13 below.

(1) To qualify for any type of disproportionate share payment adjustment, a hospital must have a Medicaid inpatient utilization rate (calculated by dividing Medicaid patient days by total patient days) of not less than 1%.

(2) The total of all disproportionate share payments awarded to a particular hospital under 114.1 CMR 40.11 through 114.1 CMR 40.13 shall not exceed the costs incurred during the year of furnishing hospital services to

individuals who either are eligible for Medicaid or have no health insurance or source of third party coverage, less payments by Medicaid and by uninsured patients.

40.11 Federally Mandated Disproportionate Share Adjustments

(1) Data Sources. The Division shall determine for each fiscal year a federally-mandated Medicaid disproportionate share adjustment for all eligible hospitals, using the data and methodology described below. The Division shall use the following data sources in its disproportionate share adjustment, unless the specified data source is unavailable. If the specified data source is unavailable, then the Division shall determine and use the best alternative data source.

(a) The prior year RSC-403 report shall be used to determine Medicaid days, total days, Medicaid inpatient net revenues, total inpatient net revenues, total inpatient charges and free care charge-offs. If said RSC-403 report is not available, the Division shall use the most recent available previous RSC-403 report to estimate these variables.

(b) The hospital's audited financial statements for the prior year shall be used to determine the state and/or local government cash subsidy.

(2) Determination of Eligibility Under the Medicaid Utilization Method. The Division shall calculate a threshold Medicaid inpatient utilization rate to be used as a standard for determining the eligibility of non-acute care hospitals for the federally-mandated disproportionate share adjustment. The Division shall determine such threshold as follows:

(a) First, calculate the statewide weighted average Medicaid inpatient utilization rate by dividing the sum of Medicaid days for all non-acute care hospitals in the state by the sum of total inpatient days for all non-acute care hospitals in the state.

(b) Second, calculate the statewide weighted standard deviation for Medicaid inpatient utilization statistics.

(c) Third, add the statewide weighted standard deviation for Medicaid inpatient utilization to the statewide weighted average Medicaid inpatient utilization rate. The sum of these two numbers shall be the threshold Medicaid inpatient utilization rate.

(d) The Division shall then calculate each hospital's Medicaid inpatient utilization rate by dividing each hospital's Medicaid inpatient days by its total inpatient days. If this hospital-specific Medicaid inpatient utilization rate equals or exceeds the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 40.11(2)(c), then the hospital shall be eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method.

(3) Determination of Eligibility Under the Low-Income Utilization Rate Method. The Division shall then calculate each hospital's low-income utilization rate. The Division shall make such determination as follows:

(a) First, calculate the Medicaid and subsidy share of net revenues by dividing the sum of Medicaid net revenues and state and local government subsidies by the sum of total net revenues and state and local government subsidies.

(b) Second, calculate the free care percentage of total inpatient charges by dividing the inpatient share of audited free care charge-offs by total inpatient charges.

(c) Third, compute the low-income utilization rate by adding the Medicaid and subsidy share of net revenues calculated pursuant to 114.1 CMR 40.11(3)(a) to the free care percentage of total inpatient charges calculated pursuant to 114.1 CMR 40.11(3)(b). If the low-income utilization rate exceeds 25%, the hospital shall be eligible for the federally-mandated Medicaid disproportionate share adjustment under the low-income utilization rate method.

(4) Determination of Payment. The payment under the federally-mandated disproportionate share adjustment shall be calculated as follows:

(a) For each hospital determined eligible for the federally-mandated disproportionate share adjustment under the Medicaid utilization method established in 114.1 CMR 40.11(2), the Division shall divide the hospital's Medicaid utilization rate calculated pursuant to 114.1 CMR 40.11(2)(d) by the threshold Medicaid utilization rate calculated pursuant to 114.1 CMR 40.11(2)(c). The ratio resulting from such division shall be the federally-mandated disproportionate share ratio.

(b) For each hospital determined eligible for the federally-mandated disproportionate share adjustment under the low-income utilization rate method, but not found to be eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method, the Division shall set the hospital's federally-mandated disproportionate share ratio equal to one.
(c) The Division shall then determine, for the group of all eligible hospitals, the sum of federally-mandated disproportionate share ratios calculated pursuant to 114.1 CMR 40.11(4)(a) and 114.1 CMR 40.11(4)(b).
(d) The Division shall then calculate a minimum payment under the federally-mandated disproportionate share adjustment by dividing the amount of funds allocated pursuant to 114.1 CMR 40.11(5) for payments under the federally-mandated disproportionate share adjustment by the sum of the federally-mandated disproportionate share ratios calculated pursuant to 114.1 CMR 40.11(4)(c).
(e) The Division shall then multiply the minimum payment under the federally-mandated Medicaid disproportionate share adjustment by the federally-mandated Medicaid disproportionate share ratio established for each hospital pursuant to 114.1 CMR 40.11(4)(a) and (b). Except as provided in 114.1 CMR 40.10(2), the product of such multiplication shall be the payment under the federally-mandated disproportionate share adjustment.

(5) Allocation of Funds. The total amount of funds allocated for payment to non-acute care hospitals under the federally-mandated Medicaid disproportionate share adjustment requirement shall be one hundred fifty thousand dollars annually. These amounts shall be paid by the Division of Medical Assistance, and distributed among the eligible hospitals as determined pursuant to 114.1 CMR 40.11(4)(e).

40.12: Extraordinary Disproportionate Share Adjustment for Psychiatric Hospitals.

The Division shall determine for FY 1996 and succeeding years an extraordinary disproportionate share adjustment for all eligible psychiatric hospitals, using the data and methodology described in 114.1 CMR 40.12.

(1) Data Sources. The Division shall use the RSC-403 report for the fiscal year two years prior to the fiscal year of the calculation of the disproportionate share adjustment to determine the cost, free care, charge, patient day, and net revenue amounts. If said RSC-403 report is not available, the Division shall use the most recent available previous RSC-403 report to estimate these variables. If the specified data source is unavailable, then the Division shall determine and use the best alternative data source.

(2) Determination of Eligibility.
(a) In order to be eligible for the extraordinary disproportionate share payment adjustment, a psychiatric hospital must:
1. specialize in providing psychiatric/psychological care and treatment;
2. provide for special active treatment such as treatment of deafness, developmental disabilities, and the elderly;
3. accept all patients without regard to their ability to pay;
4. consist partly or wholly of locked wards;
5. meet requirements for the receipt of federal matching funds;
6. meet the low-income standard as set forth in 114.1 CMR 40.12(2)(b); and
7. meet the unreimbursed cost standard as set forth in 114.1 CMR 40.12(2)(c).
(b) Low-income standard.
1. For each psychiatric hospital, the Division shall calculate the hospital-specific low-income utilization rate as follows:
a. The Division shall divide each hospital's net Medicaid revenue by its total gross patient service revenue.
b. The Division shall divide each hospital's free care charges by its total charges.
c. The total of these percentages shall equal the hospital's low-income utilization rate.
2. If the hospital-specific low-income utilization rate exceeds 45%, then the psychiatric hospital meets the low-income standard.
(c) Unreimbursed cost standard.

1. For each psychiatric hospital, the Division shall calculate the hospital-specific unreimbursed cost percentage as follows:

a. The Division shall calculate the costs of providing hospital services to Medicaid-eligible individuals and uninsured individuals, by multiplying Medicaid RFR by the ratio of Medicaid charges plus self pay charges plus free care charges to total charges.

b. The Division shall subtract the total of Medicaid payments (excluding any disproportionate share payments) plus self pay payments, from the costs determined in 114.1 CMR 40.12(2)(c)1.a., to determine the amount of unreimbursed costs.

c. The Division shall divide the amount of unreimbursed costs determined in 114.1 CMR 40.12(2)(c)1.b. by the costs determined in 114.1 CMR 40.12(2)(c)1.a. to determine the percentage of unreimbursed costs.

2. If the hospital-specific percentage of unreimbursed costs exceeds 50%, then the psychiatric hospital meets the unreimbursed cost standard.

(3) Determination of Payment. Except as provided in 114.1 CMR 40.10(2), for each psychiatric hospital determined eligible for the extraordinary disproportionate share adjustment under 114.1 CMR 40.12(2), the payment amount shall be equal to the estimated rate year unreimbursed cost of providing hospital services to Medicaid-eligible individuals and uninsured individuals, calculated as follows:

a. First, determine the estimated rate year cost of providing hospital services to Medicaid-eligible individuals and uninsured individuals as set forth in 114.1 CMR 40.12(2)(c)1.a., substituting rate year Reasonable Financial Requirements for source data RFR.

b. Then, multiply this cost by the unreimbursed cost percentage determined pursuant to 114.1 CMR 40.12(2)(c)1.c.

(4) Payments made pursuant to this section are subject to Health Care Financing Administration approval of state plan amendments incorporating this methodology.

40.13 Extraordinary Disproportionate Share Adjustment for State Owned Special Population Hospitals.

The Division shall determine for FY 1996 and succeeding years an extraordinary disproportionate share adjustment for all eligible state owned special population hospitals using the data and methodology described below.

(1) Data Sources. The Division shall use the RSC-403 report for the fiscal year two years prior to the fiscal year of the calculation of the disproportionate share adjustment to determine the cost, free care, charge, patient day, and net revenue amounts. If said RSC-403 report is not available, the Division shall use the most recent available previous RSC-403 report to estimate these variables. If the specified data source is unavailable, then the Division shall determine and use the best alternative data source.

(2) Determination of Eligibility.

(a) In order to be eligible for the extraordinary disproportionate share payment adjustment, a state owned special population hospital must:

1. specialize in providing treatment to people with AIDS, tuberculosis patients, the medically needy homeless, multiply handicapped pediatric patients and patients with combined medical and psychiatric needs;

2. provide for special active treatment such as treatment of deafness, developmental disabilities, and the elderly;

3. accept all patients without regard to their ability to pay;

4. meet requirements for the receipt of federal matching funds;

5. meet the low-income standard as set forth in 114.1 CMR 40.13(2)(b); and

6. meet the unreimbursed cost standard as set forth in 114.1 CMR 40.13(2)(c).

(b) Low-income standard.

1. For each state owned special population hospital, the Division shall calculate the hospital-specific low-income utilization rate as follows:

a. The Division shall divide each hospital's net Medicaid revenue by its total gross patient service revenue.

b. The Division shall divide each hospital's free care charges by its total charges.

c. The total of these percentages shall equal the hospital's low-income utilization rate.

2. If the hospital-specific low-income utilization rate exceeds 45%, then the state owned special population hospital meets the low-income standard.

(c) Unreimbursed cost standard.

1. For each state owned special population hospital, the Division shall calculate the hospital-specific unreimbursed cost percentage as follows:

a. The Division shall calculate the costs of providing hospital services to Medicaid-eligible individuals and uninsured individuals, by multiplying Medicaid RFR by the ratio of Medicaid charges plus self pay charges plus free care charges to total charges.

b. The Division shall subtract the total of Medicaid payments (excluding any disproportionate share payments) plus self pay payments, from the costs determined in 114.1 CMR 40.13(2)(c)1.a., to determine the amount of unreimbursed costs.

c. The Division shall divide the amount of unreimbursed costs determined in 114.1 CMR 40.13(2)(c)1.b. by the costs determined in 114.1 CMR 40.13(2)(c)1.a. to determine the percentage of unreimbursed costs.

2. If the hospital-specific percentage of unreimbursed costs exceeds 50%, then the state owned special population hospital meets the unreimbursed cost standard.

(3) Determination of Payment. Except as provided in 114.1 CMR 40.10(2), for each state owned special population hospital determined eligible for the extraordinary disproportionate share adjustment under 114.1 CMR 40.13(2), the payment amount shall be equal to the estimated rate year unreimbursed cost of providing hospital services to Medicaid-eligible individuals and uninsured individuals, calculated as follows:

(a) First, determine the estimated rate year cost of providing hospital services to Medicaid-eligible individuals and uninsured individuals as set forth in 114.1 CMR 40.13(2)(c)1.a., substituting rate year Reasonable Financial Requirements for source data RFR.

(b) Then, multiply this cost by the unreimbursed cost percentage determined pursuant to 114.1 CMR 40.13(2)(c)1.c.

(4) Payments made pursuant to this section are subject to Health Care Financing Administration approval of state plan amendments incorporating this methodology.

40.14: Administrative Adjustment

(1) A hospital may apply at any time during the rate year for an administrative adjustment if there has been an arithmetic error in the calculation of the PAF or residential alcoholism treatment program fee. The Division will not entertain an application for an administrative adjustment, if the applicant hospital is seeking to reverse a substantive determination pursuant to 114.1 CMR 40.00.

(2) A hospital may apply at any time during the first nine months of the rate year for an administrative adjustment based on a request for a CBC pursuant to 114.1 CMR 40.08(4) or a new service pursuant to 114.1 CMR 40.08(5).

(3) An application for an administrative adjustment shall be made to the Chairman of the Division in writing and shall contain the following:

(a) The name and address of the hospital.

(b) The rate or rates sought to be reviewed.

(c) A clear, concise statement of reasons for the application for administrative adjustment.

(d) A detailed statement of financial, statistical, and related information in support of the application.

(e) If the application concerns a requested CBC or new service, all relevant documentation for that CBC or new service.

(e) Such other books, records and information as the Division may require.

(3) Within 60 days from receipt of a complete and satisfactory application for administrative adjustment, the Division will render a decision. A statement of reasons for the decision will be provided .

40.15: Administrative Review

(1) Purpose of Administrative Review. To assure that a hospital's rates are in continuing compliance with this part, the Division may at any time and upon its own motion, review the rates upon notice to the hospital.

(2) Administrative Review of Transfers of Costs. Where a hospital has reduced or increased costs by the transfer of those costs to or from other persons or entities which provide health care and services, the Division may modify Reasonable Financial Requirements to reflect the change in cost. In order to give effect to a transfer of cost each hospital must file information concerning cost, volume and revenue 30 days prior to implementation of a proposed transfer of cost, and must submit any additional information regarding the transfer of cost which the Division may require.

(3) Administrative Review and Decision. Upon notice of administrative review, a hospital shall submit such books, records, documentation, and information as the Division may require. After review, the Division will render a written decision and a statement of reasons for its decision.

40.16: Appeal

A non-acute hospital which is aggrieved by an action or failure to act under 114.1 CMR 40.00 may file an appeal within thirty (30) days to the Division of Administrative Law Appeals pursuant to the requirements of M.G.L. c. 118 G. The pendency of an appeal does not limit the Division's right to undertake administrative review under 114.1 CMR 40.00.

40.17: Severability

The provisions of 114.1 CMR 40.00 are hereby declared to be severable and if such provisions or the application of such provisions to any person or circumstances shall be held to be invalid or unconstitutional, such invalidity or unconstitutionality shall not be construed to affect the validity or constitutionality of any of the remaining provisions of 114.1 CMR 40.00 or the application of such provisions to hospitals or circumstances other than those held invalid.

40.18: Administrative Information Bulletins

The Division may, from time to time, issue administrative information bulletins to clarify its policy upon and understanding of substantive provisions of 114.1 CMR 40.00. In addition, the Division may issue administrative information bulletins which specify the information and documentation necessary to implement 114.1 CMR 40.00 if necessary for informed consideration of rate determination under 114.1 CMR 40.00.

REGULATORY AUTHORITY

114.1 CMR 40.00: M.G.L.118G; and M.G.L. c.30A, s.2.